STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	09/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA VETERANS HOME	3851 N RIVER RD WEST LAFAYETTE, IN47906

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of Complaint Number IN00097132. This visit resulted in a partially extended survey-substandard quality of care. Complaint number IN00097132 Substantiated, Federal/State deficiencies related to the allegations are cited at F223, F225, F226 and F9999. Survey dates: September 28 & 29, 2011 Extended survey dates: September 30, 2011 Facility Number: 001134 Provider Number: 155787 AIM Number: 200817200 Survey Team: Linda Campbell, RN, TC DeAnn Mankell, RN Victoria Bickel, RN (9/28/11 & 9/29/11) Census Bed Type: SNF/NF: 173 NCC: 33 Total: 206 Census Payor Type: Medicare: 14 Medicaid: 131 Other: 61	F0000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Total: 206 Sample: 8 NCC Sample: 4 Supplemental Sample: 7 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on October 3, 2011 by Bev Faulkner, RN			
F0223 SS=D	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure residents were not abused by staff related to verbal abuse for 3 of 13 residents with incidents of alleged abuse in a sample of 15. (Residents #E, #H, #I). Findings include: 1. Resident #E's clinical record was reviewed on 9/29/11 at 10:05 A.M. The record indicated the resident was admitted	F0223	1. What action was taken to correct the deficient practice for affected residents? Families and doctors were notified immediately for residents involved in reported incidences 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All alert and oriented residents hillwide were interviewed to determine if there were any staff concerns, any safety concerns and to alert them on how to report any concerns b) All staff were	10/31/2011

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	with diagnoses which included, but were not limited to, diabetes mellitus, hypertension, and depression. A Minimum Data Set (MDS) Quarterly Assessment, dated 9/8/11, indicated the resident had severe cognitive impairment, had no behaviors, did not transfer or ambulate, required extensive one-person physical assistance for bed mobility, and was totally dependent on two-person physical assistance for toilet use. A nurses' note, dated 5/15/11 at 10:20 P.M., indicated "Spoke c (with) brother. Explained that allegedly an employee may have spoken abruptly to resident and that resident is fine and voices 0 (no) concerns or fears but incident is being investigated and employee involved will not be allowed @ IVH (Indiana Veteran's Home) until investigated." A social service progress note, dated 5/17/11, indicated "Met with res (resident) on the unit and spoke with her regarding any concerns she may have. Res states she has no concerns and is doing well. No signs or symptoms of emotional distress present." A "Facility Incident Reporting Form," dated 5/15/11 at 2:00 P.M., indicated "Brief Description of Incident:...(Resident		inserviced on abuse policies and abuse reporting procedures c) All alert and oriented residents were educated on the different types of abuse 3. What measures or systemic changes were put into place to be sure this does not re-occur? a. We are extending our investigative procedures to include more in-depth staff interviews and resident interviews on all alleged incidences. b. We have changed our investigation form to assist in the above (a) 4. How will corrective actions be monitored? Investigations are being audited through our QA process daily x60 days, weekly x90 days, then monthly thereafter by the DON. 5. When will all changes be complete? October 31 st , 2011	

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	#E) was in front of the nurses station and stated multiple times that she wanted to go to bed and (CNA #5) came around the nurses station in front of (Resident #E) and stated loudly that she couldn't go to bed she needed to go to BINGO. When (Resident #E) complained (CNA #5) stated that the resident didn't have to growl at her, she could just ask nicely...Immediate action taken: The nurse removed the C.N.A. from the situation and counseled her on her speaking inappropriately to the resident and asked another staff member to care for the resident..." The CNA was suspended until the investigation was completed. Interview on 9/29/11 at 8:50 A.M., with the Director of Nursing indicated the documentation of any interviews conducted related to the investigation of the above incident couldn't be found. She indicated "they took statements but (ADON #1) can't find them." An e-mail from RN #1 to the DON, ADON #1, ADON #2, and Unit Manager #2, dated 5/16/11 at 4:51 A.M., provided by the Director of Nursing indicated "... (CNA #7) and (CNA #6) witnessed (Resident #E) asking to go to bed numerous times in the dining room and when going by the nurses station (CNA #5) came around in front of her, with her			

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	hand on the arms of the w/c (wheelchair) and in (CNA #7)'s words was loud and said that she couldn't lay down she had to go to Bingo, when (Resident #E) loudly complained (CNA #5) said 'You don't have to growl at me, just ask nicely'. (CNA #6) said her voice was 'mimicky' and mean. (CNA #6) said (CNA #5) said that she had to wait her turn...(CNA #7) said she told (CNA #5) not to talk that way and that if 'state came up it could be seen as abuse'. (CNA #5) said she just wanted (Resident #E) to hear her and (CNA #7) said she told her that she was close enough to be heard. (CNA #6) said she asked (Resident #E) if she was ok and (Resident #E) said 'Yes' and she then had someone else put (Resident #E) to bed...I told (CNA #7) and (CNA #6) that this should have been reported immediately to the supervisor on duty..." An e-mail from the DON to the ADON, dated 5/16/11 at 6:38 P.M., indicated "I heard you mention this this (sic) am but didn't realize she said all this. (CNA #7) needs to be counseled on appropriate procedure..." Documentation was lacking related to CNA #5's behavior. A reply e-mail from the ADON #1 to the DON, dated 5/17/11 at 11:30 A.M., indicated "...I still don't have the written statements yet..."			

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	An e-mail from ADON #1 to the corporation, dated 5/23/11 at 8:34 A.M., indicated "We don't feel it was abuse because there was no willful intent we decided to use education." An e-mail from Social Services #1 to ADON #1, dated 5/23/11 at 4:22 P.M., indicated ..."I did not interview any other residents..." The CNA was inserviced on abuse on 5/21/11. A "Permanent Record of Assignment," dated 9/23/11, indicated CNA #5 had been scheduled to care for Resident #E. Documentation was lacking in CNA #5's employee file to indicate there had been any disciplinary action taken related to the above incident. Interview on 9/29/11 at 10:07 A.M. with Unit Manager #2 indicated the resident "was upset with CNA #5." She indicated "if you just touch her she gets upset." She indicated CNA #5 had been assigned to the unit after the incident but "she's not assigned to her." 2. Resident #H's clinical record was reviewed on 9/30/11 at 12:35 P.M. The record indicated the resident was admitted			

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	with diagnoses which included, but were not limited to, chronic obstructive lung disease and myocardial infarction. A Minimum Data Set (MDS) annual assessment, dated 7/5/11, indicated the resident was cognitively intact. A nurses' note, dated 5/5/11 at 5:45 P.M., indicated "Res came to Nursing Station & reported that 'a girl in a blue outfit & she was just in there cussing me & (roommate name) out.' Res 'I told her I didn't know her & never seen her before & she was trying to say something about old people.' Res reported he had his light on prior to this to get assistance..." A "Facility Incident Reporting Form," dated 5/5/11 at 6:30 P.M., indicated "... (Resident #H) stated that (CNA #10) came to his room and stated she was tired of old people trying to run things. She also the (sic) resident that she didn't need this job....(Resident #H) also stated that he felt that (CNA #10) didn't need to speak to them in the manner she had..." A handwritten statement, dated 5/5/11 (no time) and signed by CNA #10, indicated "...I tried (sic) to talk to him till he tried (sic) to pull some racial crap. I told him I ain't racial but I am done w (with) that room & their attitudes. Socks changed &			

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	everything picked up. I did my job. Now I've explained it. Goodnite..." An "Investigation" form, dated 5/5/11 at 6:30 P.M., indicated "Did the incident/allegation meet the definition of abuse...Yes (circled)...Unsubstantiated (indicated by checkmark)...Agency CNA asked not to return to IVH..." Documentation was lacking related to any other staff being interviewed related to the above incident of alleged abuse. Interview on 9/30/11 at 12:45 P.M., with Resident #H indicated "That was a long time ago. I was sitting in my room minding my own business and a girl came in. I didn't know who she was. I asked what she wanted and she told me 'Shut the hell up, you old people don't know what you want.' I went and turned her in. I shouldn't be talked to like that." He indicated she had not been back to his room. 3. Resident #I's clinical record was reviewed on 9/30/11 at 10:00 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, bronchospastic lung disease, arthritis and history of congestive heart failure.			

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	A Minimum Data Set (MDS) quarterly assessment, dated 3/29/11, indicated the resident was cognitively intact and was independent in transfer, ambulation, and toilet use. A nurses' note, dated 5/5/11 at 6:30 P.M., indicated "Writer spoke c (with) Res & res stated 'she (staff) was in her taking care of (roommate name) then she popped over here & she turned my scooter and tried to get in my closet door. He then said she went back over to the other side & I told her she left my scooter on & she needed to turn it off & she said I could turn it off myself.'...She also told us 'Well I have to work. I can't sit around & sleep all day like you guys do...I was going to tell you but (roommate name) beat me to it." A "Facility Incident Reporting Form," dated 5/5/11, indicated "...She had moved (Resident #I)'s electric scooter and didn't turn it off, when (Resident #I) asked (CNA #10) to turn the scooter off she stated 'turn it off yourself.' An "Investigation" form, dated 5/5/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...Unsubstantiated (indicated by checkmark)...Agency CNA asked not to return to IVH..."			

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	Documentation was lacking related to other staff members being interviewed related to the above incident of alleged abuse. Interview on 9/30/11 at 10:10 A.M., with Resident #I indicated "We have some problems with some of them (staff) but I don't know what you're talking about." Review on 9/28/11 at 11:30 A.M., of a facility policy and procedure dated 10/20/06, provided by the Assistant Administrator, identified as current, and titled "Abuse Identification, Prevention and Reporting" indicated "...This facility operates under a zero tolerance of abuse policy...It is the intent of the Indiana Veterans' Home to assure that all Residents of this facility are free from physical, sexual, verbal and/or mental (known and/or alleged) abuse, corporal punishment, and involuntary seclusion. This federal tag relates to Complaint Number IN00097132. 3.1-27(b)			

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F0225 SS=E	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure all alleged allegations of abuse were thoroughly investigated related to verbal abuse by staff for 5 of 13 residents with allegations	F0225	1. What action was taken to correct the deficient practice for affected residents? Families and doctors were notified immediately for residents involved in reported incidences 2. How are others	10/31/2011

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	of abuse in a sample of 15. (Residents #E, #F, #G, #J, and #K). Findings include: 1. Resident #E's clinical record was reviewed on 9/29/11 at 10:05 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus, hypertension, and depression. A Minimum Data Set (MDS) Quarterly Assessment, dated 9/8/11, indicated the resident had severe cognitive impairment, had no behaviors, did not transfer or ambulate, required extensive one-person physical assistance for bed mobility, and was totally dependent on two-person physical assistance for toilet use. A nurse's note, dated 6/13/11 at 11:45 A.M. indicated "Resident told SW (social worker) that she was upset c (with) CNA tx (treatment) c (with) her earlier during care (see SW note 6/13)...." A "Social Services Notes," dated 6/13/11, indicated "Writer went to meet res (resident) in her room to conduct BIMS/PHQ-9 (cognitive tests). Res immediately tells writer she is upset. Res explains that she was treated roughly by an aide when she was turning her. Nurse		identified and what corrective action will be taken to prevent it from occurring to others? a) All alert and oriented residents hillwide were interviewed to determine if there were any staff concerns, any safety concerns and to alert them on how to report any concerns b) All staff were inserviced on abuse policies and abuse reporting procedures c) All alert and oriented residents were educated on the different types of abuse 3. What measures or systemic changes were put into place to be sure this does not re-occur? a. We are extending our investigative procedures to include more in-depth staff interviews and resident interviews on all alleged incidences. b. We have changed our investigation form to assist in the above (a) 4. How will corrective actions be monitored? Investigations are being audited through our QA process daily x60 days, weekly x90 days, then monthly thereafter by the DON. 5. When will all changes be complete? October 31 st , 2011	

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	came into the room and listened to resident's concern. Re-assured res that aide will no longer be providing her care..." A handwritten note, dated 6/13/11 at 12:00 P.M., and signed by CNA #8 (the CNA in the allegation) indicated no roughness in handling the resident had occurred. A handwritten note, dated 6/13/11 at 11:30 A.M., and signed by RN #2 indicated "Writer was in res room to complete tx. Res was in bed c (with) negative deamener (sic). Tx completed s (without) difficulty. CNA into res room to complete ADLs (activities of daily living)." Documentation was lacking related to the allegation of roughness of the resident. There were no other staff interviews available for review. An "Investigation" form, dated 6/13/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...CNA could return after reviewing abuse policy...Unsubstantiated (indicated by checkmark)..." An e-mail from SS #1 to ADON #2, dated 6/13/11, indicated "...She was upset today but calmed when told the aide would not be back to care for her..."			

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	An e-mail from ADON #2 to Clerk #1, DON, ADON #1, and SS #1, dated 6/16/11, indicated "(CNA #8 may come back. Please have the agency go over Abuse policy with her and send doc (documentation) of such. Also SS rec (recommends) that maybe she not work on (unit name) for 3-4 weeks..." Interview on 9/29/11 at 10:00 A.M., with cognitively impaired Resident #E, when asked if staff treated her well, first indicated no and then indicated yes. Interview on 9/29/11 at 1:00 P.M., with ADON #1 indicated if staff didn't witness the alleged incident of abuse, no staff were interviewed. 2. Resident #K's clinical record was reviewed on 9/30/11 at 10:15 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to severe degeneration of left shoulder, and schizophrenia. A Minimum Data Set (MDS) 5-Day assessment, dated 8/26/11, indicated the resident was moderately impaired in cognitive decision-making skills, was non-ambulatory, and required extensive two-person physical assistance for toilet use.			

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A "Facility Incident Reporting Form," dated 5/15/11 at 2:00 P.M., indicated "... (Resident #K) was sitting in his recliner in the hallway yelling out and (CNA #5) was overheard to say to (Resident #K) to be quiet or he would go to bed and not go to BINGO...The nurse removed the C.N.A. from the situation and counseled her on her speaking inappropriately to the resident and asked another staff member to care for the residents..." A follow-up report indicated "...the C.N.A. will have education before returning to work on her floor..."

An e-mail from RN #1 to the DON, ADON #1, Unit Manager #2, and ADON #2, dated 5/16/11 at 4:51 A.M., indicated "...(CNA #6) reported to me that he overheard (CNA #5) tell (Resident #K) in the hallway when he was yelling to be quiet or she would put him to bed and he wouldn't get to go to Bingo...(Resident #K) was just crying about his mommy dying..."

An e-mail from ADON #1 to corporation, dated 9/23/11 at 7:12 A.M., indicated "We don't feel it was abuse because there was no willful intent we decided to use education..."

An e-mail from SS #1 to ADON #1, dated

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	155787	A. BUILDING 00 B. WING	09/30/2011

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	9/23/11, indicated "...I did not interview any other residents..." Documentation was lacking to indicate any other residents or staff had been interviewed related to the above incident of abuse. Interview on 9/29/11 at 8:50 A.M., with the DON indicated statements had been taken from staff and residents but "(ADON #1) can't find them." Interview on 9/29/11 at 1:00 P.M., with the Administrator indicated the CNA had been employed on a psychiatric unit previously and had cared for Resident #K there. He indicated "it's a mindset from the state hospital." He indicated CNA #5 had been inserviced on the abuse policy and resident rights previously. An attempt was made to interview Resident #K on 9/30/11 at 10:30 A.M. The resident did not respond to questions when asked. 3. Resident #F's clinical record was reviewed on 9/29/11 at 9:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, coronary artery disease, cerebrovascular accident (stroke), renal insufficiency, and gastrointestinal bleed.			

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A Minimum Data Set (MDS) significant change assessment, dated 8/9/11, indicated the resident was cognitively intact.

A "Facility Incident Reporting Form," dated 9/20/11, indicated "...The resident and family reported today 9/23/11, that the QMA 'slammed her dinner tray down on the table and walked away and didn't help her.' The resident reported that she was afraid of the employee..." The QMA was suspended pending completion of an investigation.

An e-mail from RN #3 to ADON #1, dated 9/23/11, indicated "...Resident thinks this employee does not like her and because of this the resident is afraid of this employee. Resident denies that this employee has harmed the resident. The employee identified by the resident is (CNA #9). Resident also stated she thinks the is (sic) employee is waiting for the opportunity to irritate her..."

An "Investigation" form, dated 9/23/11, indicated "...Resident stated that employee slammed a tray down on the over bed table & res is afraid of employee...Did the incident/allegation meet the definition of abuse...Yes (circled)...Resident felt it was willful...Residents were interviewed. No

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	other staff present...Resident states she has not been harmed but continues to be afraid. She has been using a pocket talker rests on her abd (abdomen) which could have intensified noise...Unsubstantiated (indicated by X)...(CNA #9) returned to work & has been re-educated on the policy...Continues to be afraid of employee but can't state why..." Documentation was lacking related to any other staff being interviewed related to the above incident of alleged abuse. An e-mail from the Psychiatric Services Specialist to ADON #1, dated 9/26/11, indicated "Did you talk to the alert and oriented residents on (unit name) on Friday? If so can you tell me who they were and what they said. I need to get the employee back to work." Interview on 9/29/11 at 1:00 P.M., with ADON #1 indicated no other staff members had been interviewed. She indicated the resident continues to state she's afraid of the employee. ADON #1 indicated "she probably passes meds to her." Interview on 9/29/11 at 1:00 P.M. with the Administrator, indicated "I am not going to hire new staff every time someone says they're afraid of staff. We			

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	don't have the funds to do that. I won't move people around. That's not going to happen." On 9/29/11 at 9:20 A.M., an attempt was made to interview Resident #F. The resident refused entrance to her room and would not speak with surveyor. 4. Resident #J's clinical record was reviewed on 9/30/11 at 10:40 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, insomnia, depression, anxiety, dementia, and psychosis. A Minimum Data Set (MDS) quarterly assessment, dated 8/29/11, indicated the resident was severely impaired in cognitive decision-making skills, was non-ambulatory, and required extensive two-person physical assistance for bed mobility, transfer, and toilet use. A nurses' note, dated 6/17/11 at 3:30 P.M., indicated "Informed by night aide in a written note, resident indicated improper treatment of him by the CNAs from day shift..." A handwritten note, dated 6/17/11 and signed by LPN #2, indicated "...(Resident #J) told me in a not so polite way that 2 aides that either got him up or put him to			

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	bed was (sic) very rough with him that they bumped his head either on the chair or the hoyer. He was so worked up over it I couldn't make out which. I reported it to (name)..." A "Facility Incident Reporting Form," dated 6/16/11, indicated "...Resident is alert and oriented with some forgetfulness...He reports that 2 aides that got him up or put him to bed was 'rough' with him, that they bumped his head. He is a hoyer lift...Per investigation with staff it was noted that resident did not get out of bed at all that day...CNA's will be inserviced on the hoyer lift..." Documentation was lacking related to identifying who the staff was who had worked the day of the alleged incident. An "Investigation" form, dated 6/17/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...After investigation - it was noted that resident did not get OOB (out of bed) that day! (per Unit Manager)...Unsubstantiated (indicated by checkmark)..." Documentation was lacking related to identification of staff involved in incident or documentation of any other staff interviews related to the incident of alleged abuse. 5. Resident #G's clinical record was			

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	reviewed on 9/29/11 at 11:00 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, posthypoxic encephalopathy, seizures, difficulty sleeping, cancer and severe chronic obstructive pulmonary disease. A Minimum Data Set (MDS) quarterly assessment, dated 6/16/11, indicated the resident was cognitively intact and was independent in transfers, ambulation, and toilet use. Nurses' notes, dated 9/10/11 at 10:30 A.M,. indicated "Resident reported to nurse aide that gave her a shower today, that a week ago a male aide showered her and choked her with her cross necklace she had on - another nurse aide stated that a week ago she told her the same thing but it was a week prior to that - states necklace is missing - was possible that when aide took shirt off, necklace got caught and came off...while security was doing search, resident changed her story to male aide came up behind her while she was naked and choked her with the necklace and then took it. Supervisor notified." Documentation was lacking related to an investigation being conducted the week prior to 9/10/11, when the resident			

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	reported it to a CNA. A social service note, dated 9/12/11, indicated "...Met with resident to follow up regarding allegation against staff - although resident can not identify who the complaint is about. Resident maintains allegations, although there does not appear to be evidence to support allegations..." A "Facility Incident Reporting Form," dated 9/10/11, indicated "Resident is alert, but has periods of confusion. She reported to a staff member, that approx (approximately) 2 weeks ago, while she was in the shower room a male who was giving her a shower came up behind her, grabbed her cross necklace and tried to pull it off. She said it was choking her until it broke. She does not remember who it was poss (possibly) a male CNA named (name). She later reports it was stollen (sic)...no male CNA named (name) on schedule to work..." A handwritten note, dated 9/10/11 and signed by (CNA #11), indicated "...She also informed me that she reported him. (she did not know his name, just that he had a smirk on his face)..." A handwritten note, dated 9/10/11 and signed by (CNA #12), indicated			

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	"...Approx 2 weeks ago a male aid (sic) agency '(name)' gave (Resident #G) a shower in late afternoon. At that time had not heard any issues or problems or complaints. About a week ago, (Resident #G) mentioned that someone came up behind her & stole her cross when she got a shower from a male aid (sic). Mentioned it to (LPN #2) agency nurse - said she had heard something about it already. It happened when her sweater pulled off her necklace." A handwritten note, dated 9/12/11 and signed by ADON #2, indicated "Spoke c (with) (LPN #2) per phone about incident c (with) (Resident #G). She states she does not recall being informed of any incidents. Informed her to review P&P (policy and procedure) on abuse before returning to IVH. She states she is aware & understands the importance of notifying management of any c/o (complaints of) abuse to be investigated!" An "Investigation" form, dated 9/10/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...(CNA #13) reviewed abuse policy...(LPN #2) reviewed abuse policy...Res has a history of making false statements - (CNA #13) states he does not recall her wearing any jewelry & she did most of her bathing			

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	herself...Unsubstantiated (indicated by checkmark)..." Interview on 9/29/11 at 1:00 P.M. with the DON, the DON indicated the incident had not been reported or investigated prior to 9/10/11. An e-mail 4/27/11 at 3:28 P.M. from ADON #2 to RN #4, RN #5, RN #6, RN #1, RN #7, the Broad Band Executive, the DON, and ADON #1 indicated "Past couple of months we have noticed an increase of theft and 'abuse' on (unit name) which have had to be reportables. The issue is that these are a lot of reportables on one unit so we need to show that we are aware and that we have put something in place...I will just need to have some kind of proof if state would come in to show them..." Interview on 9/29/11 at 1:15 P.M., with the Administrator indicated "If somebody says they don't want staff in the room, I won't hire additional staff. I won't replace the staff. It's not going to happen. You can't tell everyone not to come in the room. I don't care what CMS says. You do what you (ISDH) want." The Administrator indicated staff were not to discuss issues with ISDH unless he was there and instructed staff to leave the room.			

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	This federal tag relates to Complaint Number IN00097132. 3.1-28(d) 3.1-28(e)			
F0226 SS=E	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to ensure facility policies and procedures were implemented related to verbal abuse by staff for 5 of 13 residents with allegations of abuse in a sample of 15. (Residents #E, #F, #G, #J, and #K). Findings include: 1. Resident #E's clinical record was reviewed on 9/29/11 at 10:05 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, diabetes mellitus,	F0226	1. What action was taken to correct the deficient practice for affected residents? Families and doctors were notified immediately for residents involved in reported incidences 2. How are others identified and what corrective action will be taken to prevent it from occurring to others? a) All alert and oriented residents hillwide were interviewed to determine if there were any staff concerns, any safety concerns and to alert them on how to report any concerns b) All staff were inserviced on abuse policies and abuse reporting procedures c) All alert and oriented residents were educated on the different types of	10/31/2011

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	hypertension, and depression. A Minimum Data Set (MDS) Quarterly Assessment, dated 9/8/11, indicated the resident had severe cognitive impairment, had no behaviors, did not transfer or ambulate, required extensive one-person physical assistance for bed mobility, and was totally dependent on two-person physical assistance for toilet use. A nurse's note, dated 6/13/11 at 11:45 A.M., indicated "Resident told SW (social worker) that she was upset c (with) CNA tx (treatment) c (with) her earlier during care (see SW note 6/13)...." "Social Services Notes," dated 6/13/11, indicated "Writer went to meet res (resident) in her room to conduct BIMS/PHQ-9 (cognitive tests). Res immediately tells writer she is upset. Res explains that she was treated roughly by an aide when she was turning her. Nurse came into the room and listened to resident's concern. Re-assured res that aide will no longer be providing her care..." A handwritten note, dated 6/13/11 at 12:00 P.M. and signed by CNA #8 (the CNA in the allegation) indicated no roughness in handling the resident had occurred.		abuse 3. What measures or systemic changes were put into place to be sure this does not re-occur? a. We are extending our investigative procedures to include more in-depth staff interviews and resident interviews on all alleged incidences. b. We have changed our investigation form to assist in the above (a) 4. How will corrective actions be monitored? Investigations are being audited through our QA process daily x60 days, weekly x90 days, then monthly thereafter by the DON. 5. When will all changes be complete? October 31 st , 2011	

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	A handwritten note, dated 6/13/11 at 11:30 A.M. and signed by RN #2, indicated "Writer was in res room to complete tx. Res was in bed c (with) negative deamener (sic). Tx completed s (without) difficulty. CNA into res room to complete ADLs (activities of daily living)." Documentation was lacking related to the allegation of roughness of the resident. There were no other staff interviews available for review. An "Investigation" form, dated 6/13/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...CNA could return after reviewing abuse policy...Unsubstantiated (indicated by checkmark)..." An e-mail from SS #1 to ADON #2, dated 6/13/11, indicated "...She was upset today but calmed when told the aide would not be back to care for her..." An e-mail from ADON #2 to Clerk #1, DON, ADON #1, and SS #1, dated 6/16/11, indicated "(CNA #8 may come back. Please have the agency go over Abuse policy with her and send doc (documentation) of such. Also SS rec (recommends) that maybe she not work on (unit name) for 3-4 weeks..."			

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	Interview on 9/29/11 at 10:00 A.M. with cognitively impaired Resident #E, when asked if staff treated her well, first indicated no and then indicated yes. Interview on 9/29/11 at 1:00 P.M., with ADON #1 indicated if staff didn't witness the alleged incident of abuse, no staff were interviewed. 2. Resident #K's clinical record was reviewed on 9/30/11 at 10:15 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to severe degeneration of left shoulder, and schizophrenia. A Minimum Data Set (MDS) 5-Day assessment, dated 8/26/11, indicated the resident was moderately impaired in cognitive decision-making skills, was non-ambulatory, and required extensive two-person physical assistance for toilet use. A "Facility Incident Reporting Form," dated 5/15/11 at 2:00 P.M., indicated "... (Resident #K) was sitting in his recliner in the hallway yelling out and (CNA #5) was overheard to say to (Resident #K) to be quiet or he would go to bed and not go to BINGO...The nurse removed the C.N.A. from the situation and counseled her on her speaking inappropriately to the			

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	resident and asked another staff member to care for the residents..." A follow-up report indicated "...the C.N.A. will have education before returning to work on her floor..." An e-mail from RN #1 to the DON, ADON #1, Unit Manager #2, and ADON #2, dated 5/16/11 at 4:51 A.M., indicated "...(CNA #6) reported to me that he overheard (CNA #5) tell (Resident #K) in the hallway when he was yelling to be quiet or she would put him to bed and he wouldn't get to go to Bingo...(Resident #K) was just crying about his mommy dying..." An e-mail from ADON #1 to corporation, dated 9/23/11 at 7:12 A.M., indicated "We don't feel it was abuse because there was no willful intent we decided to use education..." An e-mail from SS #1 to ADON #1, dated 9/23/11, indicated "...I did not interview any other residents..." Documentation was lacking to indicate any other residents or staff had been interviewed related to the above incident of abuse. Interview on 9/29/11 at 8:50 A.M., with the DON indicated statements had been			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	taken from staff and residents but "(ADON #1) can't find them." Interview on 9/29/11 at 1:00 P.M., with the Administrator indicated the CNA had been employed on a psychiatric unit previously and had cared for Resident #K there. He indicated "it's a mindset from the state hospital." He indicated CNA #5 had been inserviced on the abuse policy and resident rights previously. An attempt was made to interview Resident #K on 9/30/11 at 10:30 A.M. The resident did not respond to questions when asked. 3. Resident #F's clinical record was reviewed on 9/29/11 at 9:30 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, coronary artery disease, cerebrovascular accident (stroke), renal insufficiency, and gastrointestinal bleed. A Minimum Data Set (MDS) significant change assessment, dated 8/9/11, indicated the resident was cognitively intact. A "Facility Incident Reporting Form," dated 9/20/11, indicated "...The resident and family reported today 9/23/11, that the QMA 'slammed her dinner tray down			

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	155787	A. BUILDING 00 B. WING	09/30/2011

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	on the table and walked away and didn't help her.' The resident reported that she was afraid of the employee..." The QMA was suspended pending completion of an investigation. An e-mail from RN #3 to ADON #1, dated 9/23/11, indicated "...Resident thinks this employee does not like her and because of this the resident is afraid of this employee. Resident denies that this employee has harmed the resident. The employee identified by the resident is (CNA #9). Resident also stated she thinks the is (sic) employee is waiting for the opportunity to irritate her..." An "Investigation" form, dated 9/23/11, indicated "...Resident stated that employee slammed a tray down on the over bed table & res is afraid of employee...Did the incident/allegation meet the definition of abuse...Yes (circled)...Resident felt it was willful...Residents were interviewed. No other staff present...Resident states she has not been harmed but continues to be afraid. She has bee using a pocket talker rests on her abd (abdomen) which could have intensified noise...Unsubstantiated (indicated by X)...(CNA #9) returned to work & has been re-educated on the policy...Continues to be afraid of employee but can't state why..."			

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	Documentation was lacking related to any other staff being interviewed related to the above incident of alleged abuse. An e-mail from the Psychiatric Services Specialist to ADON #1, dated 9/26/11, indicated "Did you talk to the alert and oriented residents on (unit name) on Friday? If so can you tell me who they were and what they said. I need to get the employee back to work." Interview on 9/29/11 at 1:00 P.M., with ADON #1 indicated no other staff members had been interviewed. She indicated the resident continues to state she's afraid of the employee. ADON #1 indicated "she probably passes meds to her." Interview on 9/29/11 at 1:00 P.M., with the Administrator indicated "I am not going to hire new staff every time someone says they're afraid of staff. We don't have the funds to do that. I won't move people around. That's not going to happen." On 9/29/11 at 9:20 A.M., an attempt was made to interview Resident #F. The resident refused entrance to her room and would not speak with surveyor. 4. Resident #J's clinical record was			

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	reviewed on 9/30/11 at 10:40 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, insomnia, depression, anxiety, dementia, and psychosis. A Minimum Data Set (MDS) quarterly assessment, dated 8/29/11, indicated the resident was severely impaired in cognitive decision-making skills, was non-ambulatory, and required extensive two-person physical assistance for bed mobility, transfer, and toilet use. A nurses' note, dated 6/17/11 at 3:30 P.M., indicated "Informed by night aide in a written note, resident indicated improper treatment of him by the CNAs from day shift..." A handwritten note, dated 6/17/11 and signed by LPN #2, indicated "...(Resident #J) told me in a not so polite way that 2 aides that either got him up or put him to bed was (sic) very rough with him that they bumped his head either on the chair or the hoyer. He was so worked up over it I couldn't make out which. I reported it to (name)..." A "Facility Incident Reporting Form," dated 6/16/11, indicated "...Resident is alert and oriented with some forgetfulness...He reports that 2 aides that			

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	got him up or put him to bed was 'rough' with him, that they bumped his head. He is a hoyer lift...Per investigation with staff it was noted that resident did not get out of bed at all that day...CNA's will be inserviced on the hoyer lift..." Documentation was lacking related to identifying who the staff was who had worked the day of the alleged incident. An "Investigation" form, dated 6/17/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...After investigation - it was noted that resident did not get OOB (out of bed) that day! (per Unit Manager)...Unsubstantiated (indicated by checkmark)..." Documentation was lacking related to identification of staff involved in incident or documentation of any other staff interviews related to the incident of alleged abuse. 5. Resident #G's clinical record was reviewed on 9/29/11 at 11:00 A.M. The record indicated the resident was admitted with diagnoses which included, but were not limited to, posthypoxic encephalopathy, seizures, difficulty sleeping, cancer and severe chronic obstructive pulmonary disease. A Minimum Data Set (MDS) quarterly assessment, dated 6/16/11, indicated the			

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	resident was cognitively intact and was independent in transfers, ambulation, and toilet use. Nurses' notes, dated 9/10/11 at 10:30 A.M., indicated "Resident reported to nurse aide that gave her a shower today, that a week ago a male aide showered her and choked her with her cross necklace she had on - another nurse aide stated that a week ago she told her the same thing but it was a week prior to that - states necklace is missing - was possible that when aide took shirt off, necklace got caught and came off...while security was doing search, resident changed her story to male aide came up behind her while she was naked and choked her with the necklace and then took it. Supervisor notified." Documentation was lacking related to an investigation being conducted the week prior to 9/10/11 when the resident reported it to a CNA. A social service note, dated 9/12/11, indicated "...Met with resident to follow up regarding allegation against staff - although resident can not identify who the complaint is about. Resident maintains allegations, although there does not appear to be evidence to support allegations..."			

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	A "Facility Incident Reporting Form," dated 9/10/11, indicated "Resident is alert, but has periods of confusion. She reported to a staff member, that approx (approximately) 2 weeks ago, while she was in the shower room a male who was giving her a shower came up behind her, grabbed her cross necklace and tried to pull it off. She said it was choking her until it broke. She does not remember who it was poss (possibly) a male CNA named (name). She later reports it was stollen (sic)...no male CNA named (name) on schedule to work..." A handwritten note, dated 9/10/11 and signed by (CNA #11) indicated "...She also informed me that she reported him. (she did not know his name, just that he had a smirk on his face)..." A handwritten note, dated 9/10/11 and signed by (CNA #12), indicated "...Approx 2 weeks ago a male aid (sic) agency '(name)' gave (Resident #G) a shower in late afternoon. At that time had not heard any issues or problems or complaints. About a week ago, (Resident #G) mentioned that someone came up behind her & stole her cross when she got a shower from a male aid (sic). Mentioned it to (LPN #2) agency nurse - said she had heard something about it already. It			

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	happened when her sweater pulled off her necklace." A handwritten note, dated 9/12/11, and signed by ADON #2 indicated "Spoke c (with) (LPN #2) per phone about incident c (with) (Resident #G). She states she does not recall being informed of any incidents. Informed her to review P&P (policy and procedure) on abuse before returning to IVH. She states she is aware & understands the importance of notifying management of any c/o (complaints of) abuse to be investigated!" An "Investigation" form, dated 9/10/11, indicated "...Did the incident/allegation meet the definition of abuse...Yes (circled)...(CNA #13) reviewed abuse policy...(LPN #2) reviewed abuse policy...Res has a history of making false statements - (CNA #13) states he does not recall her wearing any jewelry & she did most of her bathing herself...Unsubstantiated (indicated by checkmark)..." Interview on 9/29/11 at 1:00 P.M., with the DON indicated the incident had not been reported or investigated prior to 9/10/11. An e-mail of 4/27/11 at 3:28 P.M., from ADON #2 to RN #4, RN #5, RN #6, RN			

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	#1, RN #7, the Broad Band Executive, the DON, and ADON #1 indicated "Past couple of months we have noticed an increase of theft and 'abuse' on (unit name) which have had to be reportables. The issue is that these are a lot of reportables on one unit so we need to show that we are aware and that we have put something in place...I will just need to have some kind of proof if state would come in to show them..." Interview on 9/29/11 at 1:15 P.M., with the Administrator indicated "If somebody says they don't want staff in the room, I won't hire additional staff. I won't replace the staff. It's not going to happen. You can't tell everyone not to come in the room. I don't care what CMS says. You do what you (ISDH) want." The Administrator indicated staff were not to discuss issues with ISDH unless he was there and instructed staff to leave the room. Review on 9/28/11 at 11:30 A.M., of a facility policy and procedure, dated 10/20/06, provided by the Assistant Administrator, identified as current, and titled "Abuse Identification, Prevention and Reporting" indicated "...This presumes that instances of abuse of all Residents, even those in a coma, cause physical harm, or pain or mental			

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	anguish...The facility staff monitors the facility environment including, but not limited to...staff deployment...Employees are asked to report suspected or actual abuse immediately to the nurse in charge, or in the event the incident occurs in an area off the nursing unit, to the supervisor in that area, who will report to the nursing supervisor immediately...It is the intent of the Indiana Veterans Home to investigate all allegations (witnessed/confirmed or NOT) of abuse, neglect, involuntary seclusion or misappropriation of Resident property...Written statement will be obtained from involved parties, including the suspected employee, the Resident (if possible, as above), and potential witnesses..." This federal tag relates to Complaint Number IN00097132. 3.1-28(a)			
F9999	3.1-28 STAFF TREATMENT OF RESIDENTS (c) The facility must ensure that all alleged violations involving mistreatment,	F9999	1. What action was taken to correct the deficient practice for affected residents? Families and doctors were notified immediately for residents involved in reported incidences 2. How are others	10/31/2011

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	neglect, or abuse, including injuries of unknown source, and misappropriation of resident property, are reported immediately to the administrator of the facility and other officials in accordance with state law through established procedures, including to the state survey and certification agency. (d) The facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the investigation is in progress. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to thoroughly investigate allegations of abuse to ensure 4 of 4 residents were not physically abused in a sample of 4 residents with allegations of abuse (Residents A, B, C, and D). Findings include: 1. During the facility tour on 9/28/2011 at 10:32 A.M., with Unit Manager #1, she identified Resident C as being unable to be interviewed. Resident C's clinical record was reviewed on 9/28/2011 at 11:42 A.M.		identified and what corrective action will be taken to prevent it from occurring to others? a) All alert and oriented residents hillwide were interviewed to determine if there were any staff concerns, any safety concerns and to alert them on how to report any concerns b) All staff were inserviced on abuse policies and abuse reporting procedures c) All alert and oriented residents were educated on the different types of abuse 3. What measures or systemic changes were put into place to be sure this does not re-occur? a. We are extending our investigative procedures to include more in-depth staff interviews and resident interviews on all alleged incidences. b. We have changed our investigation form to assist in the above (a) 4. How will corrective actions be monitored? Investigations are being audited through our QA process daily x60 days, weekly x90 days, then monthly thereafter by the DON. 5. When will all changes be complete? October 31 st , 2011	

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	Resident C's diagnoses included, but were not limited to, dementia with behaviors, anxiety, Alzheimer's Disease, depression, and a history of a CVA (stroke). Review of the Nurses' notes, dated 9/24/2011 at 1330 (1:30 P.M.), LPN #1 wrote ".... Also at one point (M) (member) said in hushed tone 'I'm scared.' (W) (writer) reassured her that is a safe place and we would all care for her...." Resident C's quarterly MDS (Minimum Data Set) assessment, dated 8/12/2011, indicated she was assessed as being severely impaired for decision making skills with short and long term memory problems. She was assessed as needing extensive assistance of one person with eating. The facility provided a file with the investigation of an incident with the following information: There was a handwritten note, dated 9/12/2011 and signed by CNAs #3 and #4, indicated "(LPN #1).... told to put (Resident C) in bed when that would mean she would miss her meal. If (Resident C) is noisy I am told to put her in bed & when it gets close to time to get her up I am ordered to again to leave her in bed. So she misses her meal. When			

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	(Resident C) makes noise it unnerves (LPN #1) - she has said this many times & that she can't stand (Resident C) around her when she's like that....'" The investigation conclusion was this was unsubstantiated. The nurse was to be re-educated about meal intakes and the CNA's about abuse and the charge nurse responsibilities. Documentation was lacking related to any other staff members being interviewed related to the above incident of alleged abuse. There was an email, dated 9/20/2011 at 4:34 P.M., from ADON #1 to the Administrator indicating, "... this is the same unit that the CNA turned in last Friday. I think we need to look at moving some the CNA's off that unit...." Interview on 9/29/11 at 1:00 P.M., with the DON indicated "the CNAs don't like what she (LPN #1) is doing. All the CNAs are angry because she is making them accountable. (LPN #1) put her (Resident C) down because she needed the rest. She gave her a snack. If she's sleeping they don't wake her up. I don't know if she got lunch." 2. During the facility tour on 9/28/2011 at			

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	10:31 A.M. with Unit Manager #1, she identified Resident A as being interviewable. Resident A was interviewed on 9/29/2011 at 9:30 A.M. He indicated that LPN#1 had come into his room one day and told him he needed to take a bed bath. He indicated he told her he didn't need one. She then told him his hair smelled and that he could not lay there and stink. He indicated he told her to get out of his room. He further indicated she was a very rude person and was constantly giving him advice and he didn't like it. He said he was told she would not be coming back to take care of him, but that she had been back to take care of him. The facility incident reporting form, dated 6/19/2011, indicated the following: "Brief description of incident: Resident is alert and oriented. He had been deemed competent by the psychologist. Resident explained consequences of refusing meds by nurse and felt she was disrespectful to him." The facility unsubstantiated this complaint. Documentation was lacking related to any other staff members being interviewed			

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	related to the above incident of alleged abuse. This state tag relates to Complaint #IN00097132. 3.1-28(c) 3.1-28(d) 3.1-27 ABUSE AND NEGLECT (b) The resident has the right to be free from verbal abuse. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure an allegation of verbal abuse was thoroughly investigated for 1 allegation of verbal abuse made by 1 of 1 resident in a sample of 4 residents with allegations of abuse (Resident A). Findings include: 1. During the facility tour on 9/28/2011 at 10:31 A.M. with Unit Manager #1, she identified Resident A as being interviewable. Resident A was interviewed on 9/29/2011 at 9:30 A.M. He indicated that LPN#1			

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	had come into his room one day and told him he needed to take a bed bath. He indicated he told her he didn't need one. She then told him his hair smelled and that he could not lay there and stink. He indicated he told her to get out of his room. He further indicated she was a very rude person and was constantly giving him advice and he didn't like it. He said he was told she would not be coming back to take care of him, but that she had been back to take care of him. During a confidential interview with a staff member on 9/29/2011 at 12:50 P.M., the staff member indicated they had heard LPN #1 tell Resident A that he "stunk and he needed a bath." She further indicated she had not been interviewed by the facility about this incident. Resident A's clinical record was reviewed on 9/29/2011 at 10:46 A.M. Resident A's diagnosis included, but were not limited to, CHF (congestive heart failure), PVD (peripheral vascular disease), neuropathy, diabetes mellitus, retinopathy, and anemia. Resident A's BIMS (brief intellectual mental score) was 15 of 15. His 8/1/2011 MDS (Minimum Data Set) assessment indicated he had modified independence			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155787	A. BUILDING 00 B. WING	09/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	for decision making skills. The facility incident reporting form, dated 6/19/2011, indicated the following: "Brief description of incident: Resident is alert and oriented. He had been deemed competent by the psychologist. Resident explained consequences of refusing meds by nurse and felt she was disrespectful to him." LPN #1 was placed on suspension. The description of the incident was "Reports day nurse (LPN #1) was disrespectful to him - she cont. (continued) to pester him after he told her to get out of res. room." An email from MSW #2 to ADON #2, dated 6/20/11, indicated "....nurse over the weekend 'was pestering me about not taking a bath, not taking meds, blood test. and refusal form- which I did not sign.'" The facility unsubstantiated this complaint. Documentation was lacking related to any other staff members being interviewed related to the above incident of alleged abuse.			

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	Interview on 9/29/11 at 1:15 P.M., with the Administrator indicated "If someone says they don't want staff in the room, I won't hire additional staff. I won't replace staff. That's not going to happen. You can't tell everyone not to come in the room. I don't care what CMS says." This state tag relates to Complaint #IN00097132. 3.1-27(b)			